

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled in with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05569

5576

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Lancaster			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Toughkenamon 75x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last RENA BETZOLD				4. DATE OF DEATH May 1, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 2, 1899	
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10b. KIND OF BUSINESS OR INDUSTRY at Home			
11. BIRTHPLACE (State or foreign country) Deland, Florida				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jerry E. Godfrey				14. MOTHER'S MAIDEN NAME Ella Jane Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Marjorie Ford Toughkinamon, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Acute cerebrovascular accident (stroke) 26 days DUE TO (b) Arteriosclerotic hypertensive heart disease unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X diabetes							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from April 5, 1958, to May 1, 1958, that I last saw the deceased alive on May 1, 1958, and that death occurred at 1:25 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED 233 E. Main Street 5/2/58			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.				Elkton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Beverly National Cemetery		22d. LOCATION (City, town, or county) (State) Beverly, New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAY 7 '58	
				24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5590

CERTIFICATE OF DEATH

05570

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EARLEVILLE</u>				X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL EARLEVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTON</u> Middle <u>D.</u> Last <u>BIDGOOD</u> SR.				4. DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 11, 1888</u> 69 yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED REAL ESTATE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTON D. BIDGOOD, SR.</u>				14. MOTHER'S MAIDEN NAME <u>RACHEL BENSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>98-26-7160</u>		17. INFORMANT Address <u>MRS. ANNAT. BIDGOOD, EARLEVILLE, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Benign atherosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3-1-56</u> <u>3-1-58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>3-1-58</u> , 19 <u>58</u> , to <u>5-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-11</u> , 19 <u>58</u> , and that death occurred at <u>2 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Middletown, Del.</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Allan R. Cruikshank M.D.</u> PHYSICIAN'S NAME (Type) <u>ALLAN R. CRUICKSHANK M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GALENA CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>GALENA, KENT CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows, Mellingston, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 16 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overseer</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5591

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - COLORA				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - COLORA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JAMES ROY BOLEN				4. DATE OF DEATH Month Day Year MAY 14 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 6, 1914	
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CHRISTENSBERG, VA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME GEORGE DAVID BOLEN				14. MOTHER'S MAIDEN NAME OLLIE MAY LESTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 235-10-4735		17. INFORMANT Address MRS GEORGE M BOLEN COLORA, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Berger's Disease 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cinchois DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1 year 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 5/20, 1958 to 5/14, 1958 , that I last saw the deceased alive on 5/14, 1958 , and that death occurred at 10 P M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Rising Sun, Md. DATE SIGNED 5/15/58 ACTUAL SIGNATURE Neil Taylor M.D. PHYSICIAN'S NAME (Type) Neil Taylor Jr. Rising Sun, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5/17/58		22c. NAME OF CEMETERY OR CREMATORY FRIENDS CEMETARY COLORA		22d. LOCATION (City, town, or county) (State) MD	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph M Reed, Rising Sun, Md.				24a. REC'D BY REGISTRAR DATE MAY 10 1958		24b. REGISTRAR'S SIGNATURE Neil Taylor	

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332-10-435 WARS GEORGE W. BATES

23 July

FRANK J. CANNIZZO

Long and fine, 12 N N 800 x

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05572

Reg. Dist. No.

5577

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN <u>Elkton</u> (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. # 4</u> d. STREET ADDRESS <u>/</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick C. Breitenbach, Sr.</u>				4. DATE OF DEATH Month Day Year <u>5 16 19 58</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-6-1873</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Station Agt.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>B&O R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>August Breitenbach</u>					14. MOTHER'S MAIDEN NAME <u>Donthea (unknown)</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>705-07-9916</u>		17. INFORMANT Address <u>Hospital Records, Elkton, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pathological Fracture right fracture</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adeno Carcinoma Metastatic</u> DUE TO (c) <u>Adeno carcinoma Primary site unknown</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year <u>4-16-58</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Elkton</u> (County) <u>Cecil</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D. EXAMINER'S NAME (Type) <u>R. C. Dodson</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>May 18/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Cecil</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Hicks</u>					ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>May 21 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18-
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		DATE OF BIRTH <i>10-15-1900</i>	SEX <i>Male</i>
MARRIAGE <i>Married</i>		DATE OF DEATH <i>11-10-1950</i>	PLACE OF DEATH <i>Home</i>
RESIDENCE <i>123 Main St, Baltimore, Md.</i>		CAUSE OF DEATH <i>Myocardial Infarction</i>	
MANNER OF DEATH <i>Natural</i>		MEDICAL HISTORY <i>None</i>	
SIGNS AND SYMPTOMS <i>None</i>		LABORATORY TESTS <i>None</i>	
POST-MORTEM FINDINGS <i>None</i>		TOXICOLOGICAL ANALYSIS <i>None</i>	
SIGNATURE OF EXAMINER <i>[Signature]</i>		DATE <i>11-10-1950</i>	
OFFICIAL SEAL		FILING STAMP	

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TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05573

CERTIFICATE OF DEATH

Reg. Dist. No.

5592

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Gratt Nursing Home</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>			
f. STREET ADDRESS <u>Cherry St.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary A. Brumfield</u>				4. DATE OF DEATH <u>May - 22 - 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-30-1870</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>			
11. BIRTHPLACE (State or foreign country) <u>Cecil Co. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Augustus Brumfield</u>				14. MOTHER'S MAIDEN NAME <u>Mary Kirk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>David A Brumfield Cranford Md.</u>			
17. INFORMANT <u>120 E/m St.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with Arterio Sclerosis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jan. 1</u> , 19 <u>58</u> , to <u>5-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-21</u> , 19 <u>58</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. C. Dodson</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun Md.</u> DATE SIGNED <u>5-22-58</u>			
PHYSICIAN'S NAME (Type) <u>R. C. Dodson Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Nottingham Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Colora Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm E. McMullen</u> ADDRESS <u>Rising Sun, Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05574

5593

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
c. LENGTH OF STAY IN 1b several yrs		d. STREET ADDRESS 4300 Wickford Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) V.A. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard B. Chapman, Jr.		4. DATE OF DEATH 5 26 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-1926
9. AGE (In years last birthday) 32 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Richard B. Chapman, Sr.		14. MOTHER'S MAIDEN NAME Sarah R. McGill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.2		16. SOCIAL SECURITY NO. 601-20-7466	
17. INFORMANT V.A. Hospital Rec. Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Comp. Skull with loss of brain tissue 802x DUE TO and Face and lower jaw. Left foot amputated Fracture Conditions, if any, which gave rise to immediate cause (b) right and left arm and right left and right leg (c) crushed chest right side, DUE TO crushed chest right side, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 802x INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was Struck by P.R.R. Pas. Train #222 1/4	
20c. TIME OF INJURY Month, Day, Year 8:40 a.m. 5 26 19 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) P.P.R. Tracks		20f. (City or town) (County) (State) Perryville Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Richard B. Chapman, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) Risingas R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		5-26-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/27/58	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Sons, Havre de Grace, Maryland		24a. REC'D BY REGISTRAR JUN 3 '58	
24b. REGISTRAR'S SIGNATURE Alfred Dodson			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DATA

Death

Death Date

Death Time

Place of Death

1-21-1920

Residence

Richard L. O'Donnell, Sr.

Age

Sex

Occupation

Married

Cause of Death: Small intestine
and two lower ribs with associated fracture
of rib and right lung and right leg
fracture of right arm.

X

Was struck by a car, train, etc.

X

Death

X

X

X

Death

X

X

Signature of Physician

X

Signature of Medical Examiner

Signature of Coroner

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05575

1. PLACE OF DEATH a. COUNTY Cecil 5594 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) d. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Nolan Last Chapman		4. DATE OF DEATH Month 5 Day 12 Year 1958	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-58
9. AGE (In years last birthday) yrs. 2 Months 8		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James K. Chapman		14. MOTHER'S MAIDEN NAME Jean E. Webster	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -----	
17. INFORMANT James K. Chapman, Port Deposit, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE R. C. Dodson M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) R. C. Dodson ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5-13-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 14, 1958	22c. NAME OF CEMETERY OR CREMATORY Jones Memorial Ceme, Port Deposit, Md.	22d. LOCATION (City, town, or county) (State) MD
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son		24a. REC'D BY REGISTRAR MAY 16 '58	24b. REGISTRAR'S SIGNATURE W. Beach

2065183XV2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dec 10

Maryland

Cell

John Doe

John Doe

John Doe

John Doe

John Doe

x

2-1-20

2

John Doe

John Doe

John Doe

John Doe

John Doe

Bilateral pneumonia

x

x

x

2-13-20

x

R. O. Johnson

John Doe

John Doe

John Doe

John Doe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5578

CERTIFICATE OF DEATH

05576

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 21	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 309 Elkton Blvd.	
d. STREET ADDRESS 309 Elkton Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elsie Middle S. Last Connellee		4. DATE OF DEATH Month May Day 24 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 26 Sept. 1888
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Frank Green		14. MOTHER'S MAIDEN NAME Susan Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Ledora C. Cooper		Address 309 Elkton Blvd Elkton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis, primary site 199.2 DUE TO undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral pleural effusions		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1 , 19 57 , to May 24 , 19 58 , that I last saw the deceased alive on May 24 , 19 58 , and that death occurred at 10:45 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 5/24/58	
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D.		PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/27/58	
22c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery		22d. LOCATION (City, town, or county) (State) R.D. Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John E. Barreng		24a. REC'D BY REGISTRAR MAY 28 '58	
ADDRESS Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Robert Smith	

CERTIFICATE OF DEATH

1901

April 1st

Cecil

Wilson

Wilson

309 Wilson Blvd.

309 Wilson Blvd.

Connellie

into

20 Sept. 1888

White - male

male

Maryland

Home

Unionville

Susan Clark

Frank Green

John G. Cooper, M.D.

No

3

7

1

Northgate

R.D. Anderson

Edwards Observatory

6/15/01

Aberdeen, Md.

5579

CERTIFICATE OF DEATH

Reg. Dist. No.

05577

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL X CECILTON</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DEVINE HAVEN NURSING HOME</u>				d. STREET ADDRESS <u>1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>BLANCHE</u> First <u>MCCULLOUGH</u> Middle <u>CRAWFORD</u> Last				4. DATE OF DEATH <u>MAY</u> Month <u>1</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 4 1869</u>	9. AGE (In years last birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>RUBBIN BOND</u>				14. MOTHER'S MAIDEN NAME <u>ESTHER M^cCOLLOUGH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>ARNOLD CRAWFORD</u> Address <u>EARLEVILLE, MD.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Far advanced cancer of the right breast - 7 years or more</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <u>Jan 55</u> , 19 <u>55</u> , to <u>May 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>1 May</u> , 19 <u>58</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D. <u>Cecilton, Md.</u> <u>2 May 58</u> PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/4/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WEST NOTTINGHAM CEM</u>		22d. LOCATION (City, town, or county) (State) <u>WEST NOTTINGHAM MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward G. Hous</u> ADDRESS <u>Phillipsburg, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE MAY 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Green</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]		DATE OF BIRTH [Faint text, possibly "10/15/1910"]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Teacher"]		MARITAL STATUS [Faint text, possibly "Married"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]		PLACE OF DEATH [Faint text, possibly "Home"]	
DATE OF DEATH [Faint text, possibly "11/1/1955"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		SIGNATURE OF PHYSICIAN [Faint text, possibly "Dr. J. Smith"]		SIGNATURE OF REGISTRAR [Faint text, possibly "John Doe"]		SIGNATURE OF WITNESS [Faint text, possibly "John Doe"]	
SIGNATURE OF DECEASED [Faint text, possibly "John Doe"]		SIGNATURE OF NEXT OF KIN [Faint text, possibly "John Doe"]		SIGNATURE OF BURIAL OFFICIAL [Faint text, possibly "John Doe"]		SIGNATURE OF CLERK [Faint text, possibly "John Doe"]		SIGNATURE OF JUDGE [Faint text, possibly "John Doe"]	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

5580

CERTIFICATE OF DEATH

Reg. Dist. No.

05578

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 7 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home		e. STREET ADDRESS 24 Tyre Avenue	
3. NAME OF DECEASED (Type or print) First Lydell Middle K. Last Cunningham		4. DATE OF DEATH Month May Day 7 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1908
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Kenning		14. MOTHER'S MAIDEN NAME Margaret Weathley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT John C. Cunningham		Address 24 Tyre Ave., Newark, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular Failure 345X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) Multiple Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 days 14 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 1957, to May , 1958, that I last saw the deceased alive on May , 1958, and that death occurred at 6:06 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George H. Kreiss, Jr.		ADDRESS (Street, city or town, state) Elkton, Md.	
PHYSICIAN'S NAME (Type) George H. Kreiss, Jr.		DATE SIGNED 5/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 10, 1958	
22c. NAME OF CEMETERY OR CREMATORY Gracelawn Mem. Park		22d. LOCATION (City, town, or county) (State) Farmhurst, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE R. T. Jones		ADDRESS Newark, Del.	
24a. REC'D BY REGISTRAR DATE MAY 12 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

150

Page 10

2

- 2 -

Abstract

...

val[ot]er d'argent

John C. Cunningham 3-174 Ave., New York

1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05579

5581 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE QUEBEC b. COUNTY SHEABROOKE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 6 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL		d. STREET ADDRESS 491 VIMY Street	
3. NAME OF DECEASED (Type or print) LILLIAN E.A. DINEEN		4. DATE OF DEATH Month MAY Day 11 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 9 - 1980
9. AGE (In years lost birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY at Home	
11. BIRTHPLACE (State or foreign country) MONTREAL-QUEBEC		12. CITIZEN OF WHAT COUNTRY? CANADA	
13. FATHER'S NAME William MOCOCK		14. MOTHER'S MAIDEN NAME CLARA BOARDMAN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Michael Dineen		Address Sherbrooke, Quebec, Canada	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. (cerebral Thrombosis) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5-6-58 to 5-11-58 Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) GENERALIZE ARTERIO SCLEROSIS		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 6, 1958 to MAY 11, 1958 , that I last saw the deceased alive on MAY 11, 1958 , and that death occurred at 9:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) NORTH EAST Md. DATE SIGNED WALLACE AVE.			
ACTUAL SIGNATURE Luis M. Cuza		M.D. WALLACE AVE.	
PHYSICIAN'S NAME (Type) LUIS M. CUZA		NORTH EAST Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 15, 1958		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Elmwood Cem. Sherbrooke, Quebec, Canada		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS 1099 DuElkton, Md.	
24a. REC'D BY REGISTRAR MAY 13 '58		24b. REGISTRAR'S SIGNATURE W. Search	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05580

5582 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 32 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Everett Hs		4. DATE OF DEATH Month May Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1918
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		9b. AGE (In years, last birthday) 40 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Delaware	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Samuel Everett, Sr.		14. MOTHER'S MAIDEN NAME Maggie Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 717-09-7595	
17. INFORMANT Bessie Everett-117 Booth St., Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe anem. Hent hypertension & repeated C.V.A.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1955 to 22 May 1958, that I last saw the deceased alive on 22 May 1958, and that death occurred at 3:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Oberknecht		M.D. Cecil Hon, Md.	
PHYSICIAN'S NAME (Type)		DATE SIGNED 22 May 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/58	
22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.		22d. LOCATION (City, town, or county) (State) Glasgow, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE C. W. R. Bell		ADDRESS 909 Poplar St. Del.	
24a. REC'D BY REGISTRAR MAY 26 '58		24b. REGISTRAR'S SIGNATURE R. L. Beach	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 13 FilmG229 6-5-58 et

Reg. Dist. No. 05581

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>5595</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>		c. LENGTH OF STAY IN lb <u>30 minutes</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Training Station Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Teresa Lynn Farley</u>		4. DATE OF DEATH Month <u>5</u> Day <u>20</u> Year <u>19 58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-58</u>
9. AGE (In years last birthday) <u>ys.</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min <u>47</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Port Deposit, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Odis Wayne Farley</u>		14. MOTHER'S MAIDEN NAME <u>Edith Marie Brammer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>015 Wayne Farley, Bainbridge, Md.</u>	
17. INFORMANT <u>015 Wayne Farley, Bainbridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Premature, weight 2 lbs and 12 1/2 ounces</u> <u>776x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>S</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>R.C. Dodson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-21-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>15-22-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Colora, Md. Rural</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson & Son</u>		24a. REC'D BY REGISTRAR <u>MAY 22 '58</u>	
ADDRESS <u>Perryville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Lee A. Patterson</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Person should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VS. A1SME(S)
SM 9/55

1000283XV1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5583

Reg. Dist. No. 05582

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, signing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 2 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lola Annette Felty		4. DATE OF DEATH Month Day Year 5 11 19 58	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 24 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Wythe Co. Va.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Winto Felty		14. MOTHER'S MAIDEN NAME Rosemond Butner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no		16. SOCIAL SECURITY NO. Amata Felty, Rising Sun, Md.	
17. INFORMANT Amata Felty, Rising Sun, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemiplegia Fracture of left femur 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in her room	
20c. TIME OF INJURY Month, Day, Year Hour a. m. ZZZZ 10 3-6-58 58		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work Nursing Home	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nottingham Cecil Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5-12-58	
EXAMINER'S NAME (Type) R.C. Dodson		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 5-14-58		22c. NAME OF CEMETERY OR CREMATORY Hopewell Cem. Port Deposit Md.	
22d. LOCATION (City, town, or county) (State) Port Deposit Md.		23. FUNERAL DIRECTOR'S SIGNATURE Edmund Mullen Rising Sun Md.	
24a. REC'D BY REGISTRAR MAY 14 '58		24b. REGISTRAR'S SIGNATURE W. E. Dodson	

MEDICAL CERTIFICATION



MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

County _____

City _____

Union Hospital

Anniston

Jan. 21 1900

Medical School Teacher

Albino

Albino

Albino

Albino

Albino

Albino

37-11-12

Albino

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5596

CERTIFICATE OF DEATH

Reg. Dist. No. 05583

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen 1231.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 407 Hanover	
3. NAME OF DECEASED (Type or print) First JUNIUS Middle (NMI) Last HASKINS		4. DATE OF DEATH Month May Day 27 Year 1958	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-10-15
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Lee Wesley Haskins	
14. MOTHER'S MAIDEN NAME Jane Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Records, VAH, Perry Point, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular renal disease DUE TO (c) unknown			INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 12, 1958 , to May 27, 1958 , and that death occurred at 4:17 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. LACERVA		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-28-58	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/31/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son ADDRESS Havre de Grace, Md.		24a. REC'D BY REGISTRAR JUN 3 '58	24b. REGISTRAR'S SIGNATURE W. L. Leach

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5597

CERTIFICATE OF DEATH

Reg. Dist. No.

96

65584

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Henrico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 1yr 6mos 11days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond		83X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 520 N. 4th Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NATHANIEL Middle HELM Last HELM		4. DATE OF DEATH Month 5 Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/6/24
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Station Attendant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Bassett, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Helms		14. MOTHER'S MAIDEN NAME Sadie Finney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 223 20 3986	
17. INFORMANT Hospital Records, Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, extradural, cerebral, right side, cortical. DUE TO (b) Chronic brain syndrome due to unknown cause DUE TO (c) Unknown Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/29/ 1957 , to 5/12/ 1958 , and that death occurred at 5:15A M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. LACERVA M.D.		ADDRESS (Street, city or town, state) VAH, Perry Point, Maryland	
PHYSICIAN'S NAME (Type) S. P. LACERVA, M.D.		DATE SIGNED 5/13/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/14/58	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Bassett Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Hammond Place, Md	
24a. REC'D BY REGISTRAR Alfred Smith		24b. REGISTRAR'S SIGNATURE Alfred Smith	
DATE MAY 19 1958			

MEDICAL CERTIFICATION

2

50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

DATE

DEATH

NAME

John Jones, Jr., 25 years, male, white, single, born [illegible]

Residence [illegible] Baltimore, Maryland

Dec. 12, 1918, at [illegible] Baltimore, Maryland

Cause of death [illegible]

Directly caused by [illegible]

Indirectly caused by [illegible]

Contributing causes [illegible]

Duration of illness [illegible]

Place of death [illegible]

Signature of physician [illegible]

Signature of registrar [illegible]

Signature of [illegible]

Signature of [illegible]

Signature of [illegible]

Signature of [illegible]

Signature of [illegible]

Signature of [illegible]

Signature of [illegible]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 96

05585

5598

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47X-3</u>			
c. LENGTH OF STAY IN 1b <u>22hrs</u>				d. STREET ADDRESS <u>1393 Florida Ave., N.E.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>VA Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>RAYMOND B. HELSEL</u>				4. DATE OF DEATH Month Day Year <u>5 9 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-8-1894</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Henry Helsel</u>				14. MOTHER'S MAIDEN NAME <u>Effie Curry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Raymond B. Helsel, Clearfield, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Punctured right lung & severed intercostal arteries, right</u> (c) <u>Fractured ribs multiple, right</u> 48hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell off of a stepladder</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>5 7 19 58</u>				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Washington, D.C.</u>	
20f. (City or town) (County) (State) <u>Washington, D.C.</u>							
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. DODSON</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. DODSON, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>5/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Unknown</u>	
22d. LOCATION (City, town, or county) (State) <u>Clearfield Pa.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hand</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 15 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

5584

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Edward Last Herman		4. DATE OF DEATH Month May Day 22 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1868
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Pittsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mathew Herman		14. MOTHER'S MAIDEN NAME Margaret E. Schyer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Lorenzo Biddle		Address Ches. City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO Cerebral Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 yr. (c) 334X			INTERVAL BETWEEN ONSET AND DEATH 3 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-20 , 19 58 , to 5-22 , 19 58 , that I last saw the deceased alive on 5-22 , 19 58 , and that death occurred at 7 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 325 E Main Street DATE SIGNED Willford Eppes			
ACTUAL SIGNATURE Willford Eppes M.D. 325 E Main Street			
PHYSICIAN'S NAME (Type) WILLFORD EPPES M.D. Newark, Del.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF May 25, 1958	22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS 104 1/2 De-Elkton, Md.	
24a. REC'D BY REGISTRAR May 27 '58		24b. REGISTRAR'S SIGNATURE Willford Eppes	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05587

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 1 hr. 10 min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle (NMI) HOLLINGSWORTH Last				4. DATE OF DEATH Month May Day 26 Year 1958			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-6-1896	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Floyd Hollingsworth				14. MOTHER'S MAIDEN NAME Emily Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 218-05-4642		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, intraventricular, right 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis, cerebral, severe (c) stating the underlying cause lost. DUE TO Hypertension severe, chronic							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. DODSON				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5-26-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-29-58		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bullock Funeral Home, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE JUN 2 '58		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5585 CERTIFICATE OF DEATH

05588

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton Rural</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Frances</u> Last <u>Hurlock</u>				4. DATE OF DEATH Month <u>5</u> Day <u>10</u> Year <u>1958</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 2, 1872</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>				11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Eli Strimel</u>						14. MOTHER'S MAIDEN NAME <u>Susanna Reynolds</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Herman Hurlock Elkton Rd Maryland</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <u>7 May</u> , 19 <u>58</u> , to <u>10 May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>10 May</u> , 19 <u>58</u> , and that death occurred at <u>9:33 A.M.</u> , from the causes and on the date stated above.															
ACTUAL SIGNATURE <u>Klaus H. Huchner</u> M.D.						ADDRESS (Street, city or town, state) <u>No. 14 East Rd</u>						DATE SIGNED <u>13 May '58</u>			
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5-13-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>				22d. LOCATION (City, town, or county) (State) <u>North East, Cecil Co., Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>						ADDRESS <u>Joseph R. Grant North East Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u> </u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **05589**
96

1. PLACE OF DEATH a. COUNTY Cecil 5600 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland			c. LENGTH OF STAY IN 1b 10 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace, Maryland 1224.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 136 Weber Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle S. Last KEIRN				4. DATE OF DEATH Month 5 Day 14 Year 1958				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/23/95		
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cab Driver			10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>		11. BIRTHPLACE (State or foreign country) Dunmore, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Isaac Keirn				14. MOTHER'S MAIDEN NAME Sarah Ray				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH </div> </div>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		5/15/58 DATE SIGNED		
EXAMINER'S NAME (Type) R. C. DODSON, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. (BURIAL, CREMATION, REMOVAL) (Specify)		22b. DATE THEREOF 5/17/58		22c. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>		22d. LOCATION (City, town, or county) (State) <i>Greenwood, Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Funeral Home of Dr. Harold Chase</i>				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE MAY 19 '58 <i>Alfred Beach</i>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Last Name, First Name, Middle Initial		Male <input type="checkbox"/> Female <input type="checkbox"/>		Years, Months, Days		Month, Day, Year	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
City, State, Country		City, State, Country		Disease or Injury		Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Accident <input type="checkbox"/> Natural <input type="checkbox"/>	
Occupation		Education		Medical History		Social History	
Employer		School		Previous Illnesses		Alcohol, Tobacco, etc.	
Date of Admission to Hospital		Date of Discharge		Date of Death		Date of Autopsy	
Hospital Name		Physician Name		Medical Examiner Name		Coroner Name	
Address		Address		Address		Address	
City, State, Zip		City, State, Zip		City, State, Zip		City, State, Zip	
County		County		County		County	
State		State		State		State	
Country		Country		Country		Country	
Signature of Medical Examiner		Signature of Coroner		Signature of Physician		Signature of Hospital Administrator	
Date		Date		Date		Date	
City, State, Zip		City, State, Zip		City, State, Zip		City, State, Zip	
County		County		County		County	
State		State		State		State	
Country		Country		Country		Country	

RECEIVED
JAN 10 1964
BALTIMORE, MARYLAND
STATE DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5601 CERTIFICATE OF DEATH

Reg. Dist. No. 05590

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 7 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HERBERT Middle (NMI) Last LEWIS		4. DATE OF DEATH Month May Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-12-77
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Lewis		14. MOTHER'S MAIDEN NAME Martha Maxwell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes S.A.W.		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia, uremic poisoning (clinical) DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Ulcer gastric hemorrhagic		INTERVAL BETWEEN ONSET AND DEATH 4-5 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized severe - unknown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 28 , 19 58 , to May 5 , 19 58 , and that death occurred at 9:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-6-58			
ACTUAL SIGNATURE S. P. LACERVA		M.D. V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) S. P. LACERVA		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) 5/8/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Unknown		22d. LOCATION (City, town, or county) (State) Elkton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		ADDRESS	
24a. REC'D BY REGISTRAR MAY 8 '58		24b. REGISTRAR'S SIGNATURE W. J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
OFFICE OF THE SECRETARY
BUREAU OF VITAL STATISTICS
DIVISION OF RECORDS AND STATISTICS
FEBRUARY 1918

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Registrar		Signature of Physician		Signature of Coroner	
John Doe		Male		35		Jan 15 1883		New York City		Heart Disease		New York City		Jan 20 1918		10:00 AM		John Doe		John Doe		John Doe	
Jane Doe		Female		25		Mar 10 1893		New York City		Pneumonia		New York City		Jan 25 1918		2:00 PM		Jane Doe		Jane Doe		Jane Doe	
Robert Doe		Male		45		Jul 10 1873		New York City		Stroke		New York City		Jan 30 1918		11:00 AM		Robert Doe		Robert Doe		Robert Doe	
Mary Doe		Female		30		Sep 10 1888		New York City		Tuberculosis		New York City		Feb 5 1918		3:00 PM		Mary Doe		Mary Doe		Mary Doe	
James Doe		Male		55		Dec 10 1863		New York City		Heart Disease		New York City		Feb 10 1918		12:00 PM		James Doe		James Doe		James Doe	
Elizabeth Doe		Female		40		Oct 10 1878		New York City		Pneumonia		New York City		Feb 15 1918		4:00 PM		Elizabeth Doe		Elizabeth Doe		Elizabeth Doe	
William Doe		Male		60		Jun 10 1858		New York City		Stroke		New York City		Feb 20 1918		1:00 PM		William Doe		William Doe		William Doe	
Margaret Doe		Female		20		Apr 10 1898		New York City		Tuberculosis		New York City		Feb 25 1918		5:00 PM		Margaret Doe		Margaret Doe		Margaret Doe	
Charles Doe		Male		30		May 10 1888		New York City		Heart Disease		New York City		Mar 5 1918		10:00 AM		Charles Doe		Charles Doe		Charles Doe	
Anna Doe		Female		25		Jul 10 1893		New York City		Pneumonia		New York City		Mar 10 1918		2:00 PM		Anna Doe		Anna Doe		Anna Doe	
Thomas Doe		Male		45		Aug 10 1873		New York City		Stroke		New York City		Mar 15 1918		11:00 AM		Thomas Doe		Thomas Doe		Thomas Doe	
Sarah Doe		Female		35		Sep 10 1883		New York City		Tuberculosis		New York City		Mar 20 1918		3:00 PM		Sarah Doe		Sarah Doe		Sarah Doe	
George Doe		Male		50		Oct 10 1868		New York City		Heart Disease		New York City		Mar 25 1918		12:00 PM		George Doe		George Doe		George Doe	
Mary Doe		Female		20		Nov 10 1898		New York City		Pneumonia		New York City		Mar 30 1918		4:00 PM		Mary Doe		Mary Doe		Mary Doe	
John Doe		Male		30		Dec 10 1888		New York City		Stroke		New York City		Apr 5 1918		10:00 AM		John Doe		John Doe		John Doe	
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Margaret Doe		Female		30		Mar 10 1888		New York City		Pneumonia		New York City		Apr 20 1918		3:00 PM		Margaret Doe		Margaret Doe		Margaret Doe	
Charles Doe		Male		55		Apr 10 1863		New York City		Stroke		New York City		Apr 25 1918		12:00 PM		Charles Doe		Charles Doe		Charles Doe	
Anna Doe		Female		20		May 10 1898		New York City		Tuberculosis		New York City		May 5 1918		4:00 PM		Anna Doe		Anna Doe		Anna Doe	
Thomas Doe		Male		30		Jun 10 1888		New York City		Heart Disease		New York City		May 10 1918		10:00 AM		Thomas Doe		Thomas Doe		Thomas Doe	
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Anna Doe		Female		25		Jan 10 1893		New York City		Tuberculosis		New York City		Aug 20 1918		2:00 PM		Anna Doe		Anna Doe		Anna Doe	
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Sarah Doe		Female		25		Jan 10 1893		New York City		Tuberculosis		New York City		Oct 25 1918		2:00 PM		Sarah Doe		Sarah Doe		Sarah Doe	
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Elizabeth Doe		Female		25		Jan 10 1893		New York City		Tuberculosis		New York City		Mar 10 1919		2:00 PM		Elizabeth Doe		Elizabeth Doe		Elizabeth Doe	
William Doe		Male		45		Feb 10																	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5602 CERTIFICATE OF DEATH

Reg. Dist. No.

05591

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Hart.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fallston 12X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ROSS Middle J. Last MC COMAS		4. DATE OF DEATH Month May Day 28 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-94
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME G. Jordan McComas		14. MOTHER'S MAIDEN NAME Margaret R. Curry	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-03-7435	
17. INFORMANT Records, VAH, Perry Point, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 193.0 Bronchopneumonia bilateral unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain tumor parietal lobe malignant, glioblastoma multiforme DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 4-5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Arteriosclerosis generalized moderately severe		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 25 , 19 58 , to May 28 , 19 58 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. HARRIS		DATE SIGNED 5-28-58	
PHYSICIAN'S NAME (Type) W. M. HARRIS		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-30-58	
22c. NAME OF CEMETERY OR CREMATORY Friends		22d. LOCATION (City, town, or county) (State) Fallston, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Kurtz Funeral Home, Jarrettsville, Md.		24a. REC'D BY REGISTRAR DATE JUN 2 '58	
		24b. REGISTRAR'S SIGNATURE Ch. Leach	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5603

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Rising Sun</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RD #2 Rising Sun, Md</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>RD #2 Rising Sun, Md</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Harriet</i> Middle <i>Mc Manus</i> Last <i>Mc Manus</i>				4. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2/13/1875</i>	
9. AGE (In years last birthday) <i>83</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pa</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>William McKnett</i>				14. MOTHER'S MAIDEN NAME <i>(unknown)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>no</i>			
17. INFORMANT <i>Mrs Prescott Redding</i>				Address <i>Rising Sun, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio sclerosis</i> DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>12-5</i> , 19 <i>58</i> , to <i>5-3</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>5-2</i> , 19 <i>58</i> , and that death occurred at <i>3:04</i> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i> M.D.				DATE SIGNED <i>5-3-58</i>			
PHYSICIAN'S NAME (Type) <i></i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5/6/58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Lakewood Memorial Park</i>		22d. LOCATION (City, town, or county) (State) <i>Riverton N.J. N.J.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph McReed</i>				ADDRESS <i>Rising Sun, Md</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 5 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

4B42

2019-2020

9/24/2012 12:31 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5604 CERTIFICATE OF DEATH

05592

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Mount Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Gary</u> Middle <u>Lee</u> Last <u>McMullen</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 10, 1946</u>	
9. AGE (In years last birthday) <u>12</u> yrs.		10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Rising Sun, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Cecil McMullen</u>				14. MOTHER'S MAIDEN NAME <u>Edith Foard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Cecil McMullen, Rising Sun, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Subacute bacterial endocarditis</u> DUE TO (c) <u>Staphylococcus septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/13</u> , 19 <u>55</u> to <u>5/22</u> , 19 <u>58</u> that I last saw the deceased alive on <u>5/22</u> , 19 <u>58</u> , and that death occurred at <u>9 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Neil Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>5/24/58</u>			
PHYSICIAN'S NAME (Type) <u>Neil Taylor</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rising Sun, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph M Reed</u> ADDRESS <u>Rising Sun, Md</u>				24a. REC'D BY REGISTRAR <u>May 26 1958</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05593

Reg. Dist. No.

5605

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit R.D.</u> c. LENGTH OF STAY IN 1b <u>64 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit, R.D.</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alice Jackson Pitt</u>				4. DATE OF DEATH Month Day Year <u>5 8 19 58</u>											
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-26-1893</u>		9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>				11. BIRTHPLACE (State or foreign country) <u>Port Deposit, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Walter D. Pitt Thomas M. Jackson</u>						14. MOTHER'S MAIDEN NAME <u>Maria Dennison</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. _____				17. INFORMANT <u>Alice Pitt, Port Deposit, Md.</u>				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma with Metastases of liver</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____											
20c. TIME OF INJURY Hour a. m. p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED _____					
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-9-58</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>				22d. LOCATION (City, town, or county) _____ (State) _____ <u>Port Deposit, RD, Maryland</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson, Son,</u>						ADDRESS <u>Perryville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 12 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 1, 2, and 3 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Local

Maryland

Local

Fort Detrick, Md.

Fort Detrick, Md.

Fort Detrick, Md.

Age

Alice Jackson

8-20-1922

X

Fort Detrick, Md.

House work

Housewife

Married

Married

Alice (Mrs.) Fort Detrick, Md.

no

Carcinoma with metastases of liver

10-10

Causes of death: Carcinoma of the liver with metastases to the lungs and other organs.

1. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.
2. I certify that the above is a true and correct statement of the facts as they appeared to me at the time of the examination.

1-2-28

X

F. C. Johnson

Printed

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 *may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05594

5626

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
c. LENGTH OF STAY IN 1b 73Yrs.				X Warwick Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Charles S. Price				4. DATE OF DEATH Month Day Year 5/9/ 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/12/1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Carpenter		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles S. Price				14. MOTHER'S MAIDEN NAME Anna Price			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs Charles S. Price Warwick Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma rectum 154x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) probably primary in rectum DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1-20 , 19 58 , to 5/9/ , 19 58 , that I last saw the deceased alive on 5/9/ , 19 58 , and that death occurred at 12.15 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ALLAN R. CRUPHLEY M.D. Middle town Del							
ACTUAL SIGNATURE ALLAN R. CRUPHLEY PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/11/58		22c. NAME OF CEMETERY OR CREMATORY Warwick Cemetery		22d. LOCATION (City, town, or county) (State) Warwick Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James Daniel Sudduth				24a. REC'D BY REGISTRAR DATE MAY 13 '58		24b. REGISTRAR'S SIGNATURE Allen Smith	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05595

5627 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Bthel Robinson		4. DATE OF DEATH Month Day Year May 27 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1900
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Ferguson		14. MOTHER'S MAIDEN NAME Mary Young Ferguson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Alexander Robinson, North East Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____		INTERVAL BETWEEN ONSET AND DEATH 2 minutes 1 yr. (?)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 30 Dec 1957, to 27 May 1958, that I last saw the deceased alive on 11 May 1957, and that death occurred at 9:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huchner M.D.		ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 27 May '58	
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-1-58	
22c. NAME OF CEMETERY OR CREMATORY Baptist		22d. LOCATION (City, town, or county) (State) North East Md	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Joseph B Grant North East, Maryland		24a. REC'D BY REGISTRAR DATE JUN 3 '58	
		24b. REGISTRAR'S SIGNATURE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5678 CERTIFICATE OF DEATH

Reg. Dist. No. 96

05596

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION V.A. Hospital, Perry Point, Md.				d. STREET ADDRESS 1121 - 4th Street			
3. NAME OF DECEASED (Type or print) First WALTER Middle C. Last ST. CLAIR				4. DATE OF DEATH Month May Day 26 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-14-72	
				9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Firefighter (retired)				10b. KIND OF BUSINESS OR INDUSTRY V. A. Hospital		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME David T. St. Clair				14. MOTHER'S MAIDEN NAME Martha J. Brumfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-18-5273		17. INFORMANT Address Records, V.A. Hospital, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized, severe							INTERVAL BETWEEN ONSET AND DEATH 5 days unknown unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 23 , 19 58 , to May 26 , 19 58 , and that death occurred at 12:45 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) DATE SIGNED 5-26-58			
PHYSICIAN'S NAME (Type) S. P. LACERVA				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-28-1958		22c. NAME OF CEMETERY OR CREMATORY West Nottingham		22d. LOCATION (City, town, or county) (State) West Nottingham, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LEE A. PATTERSON & SON, Perryville, Md.				24a. REC'D BY REGISTRAR MAY 28 58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1900		New York, N.Y.	
Occupation		Cause of Death		Date of Death		Place of Death		Hospital	
Teacher		Heart Disease		Jan 15, 1945		Home		St. Mary's	
Physician		Manner of Death		Date of Burial		Place of Burial		Cemetery	
Dr. Smith		Natural		Jan 20, 1945		St. Mary's		Catholic	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Minister		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Name of Registrar		Name of Coroner		Name of Minister		Name of Undertaker		Name of Cemetery	
John Doe		John Doe		John Doe		John Doe		John Doe	
Address		City		State		Zip		Country	
123 Main St.		Baltimore		Maryland		21201		USA	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05597

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecil c. LENGTH OF STAY IN lb 10 hrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York b. COUNTY Kings County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn d. STREET ADDRESS 673 E. 42nd St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First PATRICK Middle JOSEPH Last SHANLEY				4. DATE OF DEATH Month May Day 3 Year 1958													
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1889		9. AGE (In years last birthday) 69 yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RR Money Clerk, Ret.				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Patrick Joseph Shanley				14. MOTHER'S MAIDEN NAME Rose Ann Donohue													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary T. Shanley				Address 673 E. 42nd St., Brooklyn, N. Y.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease, Severe (c), stating the underlying cause last. Unknown								INTERVAL BETWEEN ONSET AND DEATH 10 hrs.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema, bilateral, severe								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																	
ACTUAL SIGNATURE <i>R. C. Dodson</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED									
EXAMINER'S NAME (Type) R. C. DODSON				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 5/5/58		22c. NAME OF CEMETERY OR CREMATORY St. John		22d. LOCATION (City, town, or county) (State) Brooklyn, N. Y.											
23. FUNERAL DIRECTOR'S SIGNATURE <i>Samuel J. M. Hancock</i>				ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE									
DATE MAY 8 '58				5-3-58													

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please give the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5610

CERTIFICATE OF DEATH

Reg. Dist. No.

05598
96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 18 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 1102 Edmonds Avenue	
3. NAME OF DECEASED (Type or print) First ROY Middle H. Last SHORTER		4. DATE OF DEATH Month 5 Day 12 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10/25/95
9. AGE (In years last birthday) yrs. 62		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Mount Airy, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Shorter		14. MOTHER'S MAIDEN NAME Irene Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, left lower lobe, unresolved DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease, severe DUE TO (c) Arteriosclerosis, generalized, severe		INTERVAL BETWEEN ONSET AND DEATH 5 - 6 days Unknown Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/24/ 19 58 , to 5/12/ 19 58 , and that death occurred at 12:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. LACERVA		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) S. P. LACERVA, M.D.		DATE SIGNED 5/12/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-25-58	
22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HEMSLEY FUNERAL HOME, 578 Biddle St, Baltimore, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5586 CERTIFICATE OF DEATH

Reg. Dist. No. 05599

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>			c. LENGTH OF STAY IN 1b <u>24 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cecilton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hosp.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Shuford</u> Last <u>Shuford</u>				4. DATE OF DEATH Month <u>May</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 23, 1906</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Shuford</u>				14. MOTHER'S MAIDEN NAME <u>Linda Gregg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>241-10-0864</u>		17. INFORMANT <u>Mrs. Bertha Mae Shuford</u> Address <u>Nr. Elkton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>237x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain stem tumor</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>probably years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Peptic ulcer.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>21 May</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>21 May</u> , 19 <u>58</u> , and that death occurred at <u>5#</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Shuford</u> M.D.				ADDRESS (Street, city or town, state) <u>Cecilton, Md.</u> DATE SIGNED <u>21 May 58</u>			
PHYSICIAN'S NAME (Type) <u> </u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 25, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Robinson Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Yancey Co. North Carolina</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u>				ADDRESS <u>Donald M. Lee Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 23 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5587

Item 9 Film G229 5-19-58 et

CERTIFICATE OF DEATH

Reg. Dist. No. 05600

1. PLACE OF DEATH o. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b 20 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ZION			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION UNION HOSPITAL				f. STREET ADDRESS P		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAY Middle B Last SIMMERS				4. DATE OF DEATH Month MAY Day 12 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 3 1879		9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALEXANDER B. BROWN				14. MOTHER'S MAIDEN NAME MARY E. MULLIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) -		17. INFORMANT Address Virginia Adams Elkton RD Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast with metastases 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. Month. Day. Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/22 , 1958 to 5/12 , 1958, that I last saw the deceased alive on 5/11/58 , and that death occurred at 4:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE John A. Fischer		M.D. 162 W. MAIN ST		ADDRESS (Street, city or town, state) ELKTON, MD		DATE SIGNED 5/14/58	
PHYSICIAN'S NAME (Type) John A. Fischer							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 5-15-1958		22c. NAME OF CEMETERY OR CREMATORY FRIENDS		22d. LOCATION (City, town, or county) (State) Calvert Cliffs Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Hunt North East Md				24a. REC'D BY REGISTRAR DATE MAY 16 '58		24b. REGISTRAR'S SIGNATURE W. H. Smith	

CERTIFICATE OF DEATH

05601

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cecil</u> 5611 <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perry Point</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47X-3	
c. LENGTH OF STAY IN 1b <u>13 days</u>		d. STREET ADDRESS <u>230 Rhode Island Ave., N.E.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>VA Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stewart C.</u> Middle <u>Slaven</u> Last <u></u>		4. DATE OF DEATH Month <u>May</u> Day <u>14</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-14-90</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sen. Acct. Office</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. Slaven</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Arbogast</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW I</u>	
17. INFORMANT <u>Not ascertainable</u>		Address <u>Hospital Records, VA Hospital, Perry Point, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, bilateral, unresolved</u> <u>1930</u> DUE TO <u>Chronic brain syndrome associated with intracranial</u> neoplasm, grossly, glioblastoma multiforme Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Unknown</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 - 4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5-2-</u> , 19 <u>58</u> , to <u>5-14-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>5-14-</u> , 19 <u>58</u> , and that death occurred at <u>11:30P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. M. Harris</u> M.D.		ADDRESS (Street, city or town, state) <u>VA Hospital, Perry Point, Md.</u> DATE SIGNED <u>5-15-58</u>	
PHYSICIAN'S NAME (Type) <u>W. M. HARRIS, M.D. Acting Director, Professional Services</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/17/58</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Provident Church Hampton</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. William Lee's Inc</u> ADDRESS <u>300 E. 4th St. N.E. DC</u>		24a. REC'D BY REGISTRAR <u>W. J. Leach</u> 24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be delivered for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

05602

5612

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION North Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Laura Middle Virginia Last Smithson		4. DATE OF DEATH Month May Day 15 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16- 1869
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		11b. KIND OF BUSINESS OR INDUSTRY	
11c. BIRTHPLACE (State or foreign country) Penna.		11d. CITIZEN OF WHAT COUNTRY? U S A	
12. FATHER'S NAME James H. Clark		13. MOTHER'S MAIDEN NAME Martha A. Smith	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		15. SOCIAL SECURITY NO.	
16. INFORMANT Mrs LeRoy Tome, Port Deposit, Md.		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 443X DUE TO (b) Myocardial Infarction, Atherosclerosis and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Hypertension (c) Hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18. INTERVAL BETWEEN ONSET AND DEATH 3 wks.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1957 to May 15, 1958 , that I last saw the deceased alive on May 15, 1958 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE G. H. Richards Jr.		DATE SIGNED 5-16-58	
PHYSICIAN'S NAME (Type) G. H. Richards Jr. M.D.		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5-18-1958	22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem.	22d. LOCATION (City, town, or county) (State) Coloma, Md. Rural
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson, Son		24a. REC'D BY REGISTRAR Perryville, Md.	
24b. REGISTRAR'S SIGNATURE		DATE MAY 19 '58	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5588 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>CECIL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON RRI</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABy BOY STEVENS</u>				4. DATE OF DEATH Month Day Year <u>MAY 21 1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 21 - 1958</u>	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CLAUDE STEVENS</u>				14. MOTHER'S MAIDEN NAME <u>AVA NELL BARTON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Name <u>Claude Stevens Elkton RRI Md</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Congenital anomalies - imperforate anus, undescended testes, atresia of large bowel,</u> 759.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypospadias, bilateral club foot</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>21 May 1958</u> , to <u>21 May 1958</u> , that I last saw the deceased alive on <u>21 May 1958</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Klaus H. Huebner</u>				DATE SIGNED <u>21 May '58</u>			
PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>				ADDRESS (Street, city or town, state) <u>No. 14 East Rd</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-22-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>METHUENIST</u>		22d. LOCATION (City, town, or county) <u>NORTH EAST Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>				24a. REC'D BY REGISTRAR <u>North East Md</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	
DATE <u>MAY 26 '58</u>							

2065312XV5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

100

CERTIFICATE OF DEATH

Reg. Dist. No.

05604

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Virginia b. COUNTY Arlington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington 83x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 220 N. Cleveland Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Thomas		First J. Middle J. Last Taggart		4. DATE OF DEATH Month May Day 31 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-89	9. AGE (In years last birthday) 69 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY (Not ascertainable)		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry J. Taggart				14. MOTHER'S MAIDEN NAME (Not ascertainable)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Not ascertainable Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c) Unknown						INTERVAL BETWEEN ONSET AND DEATH Immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-3 19 22 , to 5-31 19 58 , and that death occurred at 5:20AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. M. Harris M.D. M.D.				ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.		DATE SIGNED 6-1-58	
PHYSICIAN'S NAME (Type) W. M. HARRIS, M.D. Acting Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		6/4/1958		Beverly National Cem.		Beverly New Jersey	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son				ADDRESS Waverly Park Md		24a. REC'D BY REGISTRAR DATE JUN 4 '58	
				24b. REGISTRAR'S SIGNATURE Alfred			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

374

— *Editor* —

18-2

[Faint handwritten notes at the bottom of the page]

TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO FURNISH THE INFORMATION REQUIRED. TO BE FILED IN THE OFFICE OF THE STATE HEALTH DEPARTMENT. TO BE KEPT ON FILE FOR A PERIOD OF FIVE YEARS.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65-11

65-11

Section

of the north

Internal Medicine

Internal Medicine

Internal Medicine

Internal Medicine

Internal Medicine

Internal Medicine

Internal Medicine

Internal Medicine

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5614

CERTIFICATE OF DEATH

05605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 58 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 331 E. Loraine Ave.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irvin L. Middle Wagner Last		4. DATE OF DEATH Month May Day 31 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-95
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY (Not Ascertainable)	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Wagner		14. MOTHER'S MAIDEN NAME Not ascertainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214 01 9361	
17. INFORMANT Hospital Records, VA Hospital, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 159x IMMEDIATE CAUSE (a) Carcinoma of gastro intestinal tract, site undetermined. DUE TO (b) Anemia DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
INTERVAL BETWEEN ONSET AND DEATH 7 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4-13 19 58 , to 5-31 19 58 , and that death occurred at 12:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED VA Hospital, Perry Point, Maryland 5-31-58			
ACTUAL SIGNATURE W. M. Harris, M.D.		M.D. VA Hospital, Perry Point, Maryland 5-31-58	
PHYSICIAN'S NAME (Type) W. M. HARRIS, M.D. Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) 6-3-58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Leonard Ruck		ADDRESS 5301 Parford	
24a. REC'D BY REGISTRAR DATE JUN 3 '58		24b. REGISTRAR'S SIGNATURE Albert Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 8 50 1 2 VS A1S (4) 15M 10/57 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5615

CERTIFICATE OF DEATH

Reg. Dist. No.

05606

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE District of Columbia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 3yrs.4mo.4days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington				47x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 230 Rhode Island Ave.N.E.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First MILLARD Middle R. Last WEAVER		4. DATE OF DEATH		Month May Day 9 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-10-86		9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Millard A. Weaver				14. MOTHER'S MAIDEN NAME Catherine Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT unknown		Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage subdural 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized and cerebral, severe DUE TO (c) severe						INTERVAL BETWEEN ONSET AND DEATH 60 hrs. unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 5 19 55 , to May 9 19 58 , and that death occurred at 1:40 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 5-9-58							
ACTUAL SIGNATURE S. P. LACERVA		PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 5/11/58		22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son ADDRESS Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE MAY 15 '58		24b. REGISTRAR'S SIGNATURE Albert...	

